MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06385

6427

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G262 5/11/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural — Berlin
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Vance — Last: Bryde

4. DATE OF DEATH: Month: May — Day: 2 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 25 1882

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Liverpool England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Vance Bryde

14. MOTHER'S MAIDEN NAME: Annie McGuffie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: MR. DELBERT TREMBLY WILMINGTON DEL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lived alone Didn't use MD's

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius Sr. M.D.

EXAMINER'S NAME (Type): N. E. Sartorius

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5/3/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/6/60

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or county): Berlin (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md.

24d. REC'D BY REGISTRAR — DATE: MAY 9 '60

24b. REGISTRAR'S SIGNATURE: Clarence S. Mears

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06386

6428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Whaleyville
d. STREET ADDRESS: XX
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MILTON — Middle M. — Last DALE

4. DATE OF DEATH: Month May — Day 10 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 3 1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rural mail carrier

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Mail

11. BIRTHPLACE (State or foreign country): Whaleyville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Dale

14. MOTHER'S MAIDEN NAME: Jennie Mumford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): XX
(If yes, give war or dates of service): X X

16. SOCIAL SECURITY NO.: xxx

17. INFORMANT — Address: Herman Truitt Whaleyville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (b): Coronary Artery Disease & Coronary Sclerosis — 5 yrs
DUE TO (c): Generalized Arteriosclerosis — 12 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Cystic Pyelitis & Bilateral Hydronephrosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 48, to May 10, 19 60, that I last saw the deceased alive on May 10, 19 60, and that death occurred at 2:— M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herman Rathbun M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Berlin, Md

22a. BURIAL, CREMATION, or REMOVAL: Cremation

22b. DATE THEREOF: 5/14/60

22c. NAME OF CEMETERY OR CREMATORY: Silverbrook

22d. LOCATION (City, town, or county) (State): Wilmington, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville, Del.

24a. REC'D BY REGISTRAR DATE: MAY 13 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6425

Reg. Dist. No. 06387

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Pocomoke City
d. STREET ADDRESS: 17 Gray St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fletcher — Middle: — Last: Dryden
4. DATE OF DEATH: Month: May — Day: 22, — Year: 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. , 1886
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Mill Work
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Dryden
14. MOTHER'S MAIDEN NAME: Harriet ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-05-6659A
INFORMANT: Edna Dryden Address: 7 Gray St Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Unknown — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days
DUE TO (b): Hypertensive Cardiovascular Disease, Severe — 10 yrs
DUE TO (c): Arteriosclerosis & Atherosclerosis, Mod. Severe — many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Prostatitis & Chronic Gastritis, Moderate
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1949, to 23 April, 1960, that I last saw the deceased alive on 23 April, 1960, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: N. E. Sartorius, Jr. M.D. — ADDRESS (Street, city or town, state): Pocomoke City, Md. — DATE SIGNED:
PHYSICIAN'S NAME (Type): N.E. Sartorius, Jr., M.D. — 114 Market St., Pocomoke City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 27, 1960
22c. NAME OF CEMETERY OR CREMATORY: Hall's Hill Cem.
22d. LOCATION (City, town, or county) (State): Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: JUN 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6429 **CERTIFICATE OF DEATH** Reg. Dist. No. 06388

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: xx

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bishop
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First D. Middle Ryal Last Hudson

4. DATE OF DEATH: Month May Day 19 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 5, 1897

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. Hudson

14. MOTHER'S MAIDEN NAME: Martha Esham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): xx
(If yes, give war or dates of service): xx

16. SOCIAL SECURITY NO.: xx

17. INFORMANT: Address: Mrs. Grace Hudson Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis & myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: P
DUE TO
(b): Arteriosclerotic heart disease (Had a "heart attack" 1 yr. ago treated by Dr Robins, Berlin, Md.) — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Attended by Dr Robins to (see above) that I last saw the deceased alive on _____, 19____, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl B. McFadden M.D. ADDRESS (Street, city or town, state): Selbyville, Del. DATE SIGNED: 20 May '60

PHYSICIAN'S NAME (Type): Earl B. McFADDEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/22/60

22c. NAME OF CEMETERY OR CREMATORY: I. O. O. F.

22d. LOCATION (City, town, or county) (State): Bishopville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Selbyville, Del.

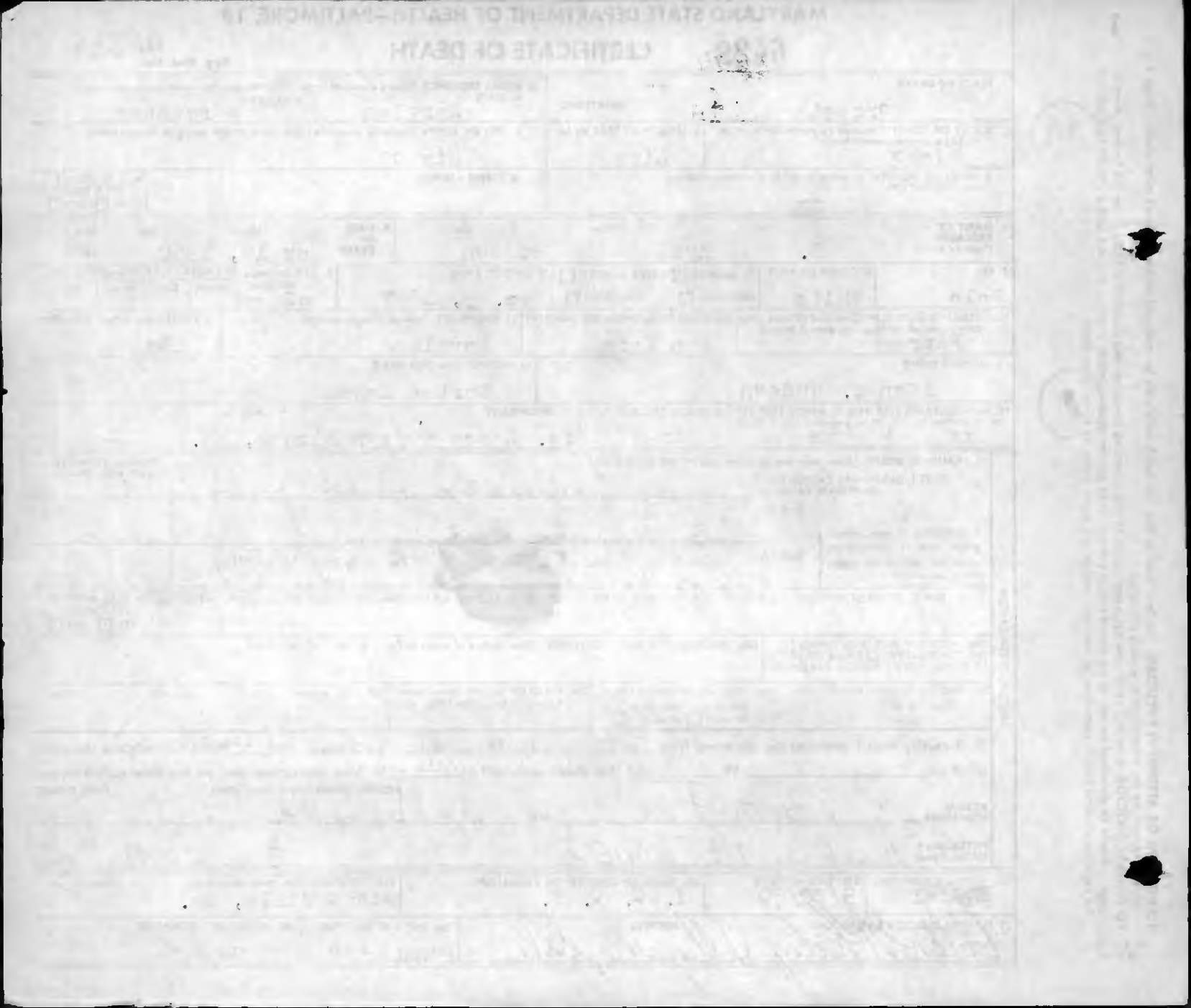
24a. REC'D BY REGISTRAR DATE: MAY 24 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kirby

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6423 — 06389 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hotel Commander

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 0210.2
d. STREET ADDRESS: 23 State Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Rose — Middle C — Last Jameson
4. DATE OF DEATH: Month May — Day 27 — Year 1960

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	WIDOWED ☒	July 10, 1910	49 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sect.	Hotel, Mgr	Pa	USA

13. FATHER'S NAME: Robert B. Fitzsimmons
14. MOTHER'S MAIDEN NAME: Grace McFeaters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No	No	380-24-0902	Mrs. Meredith L. Elder- Sister- Clairton, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

443 ✗

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19	20d. INJURY OCCURRED: While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Wm Lovett M.D.
EXAMINER'S NAME (Type): W. Lovett
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: May 29 1960

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 31, 1960	St. Mary's Cemetery	Bryantown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Hopping Funeral Home	Annapolis, Md.	DATE JUN 1 '60	Arthur L. Kraus

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6430

CERTIFICATE OF DEATH

Reg. Dist. No. 06390

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Stockton
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle E. — Last JONES

4. DATE OF DEATH: Month May — Day 22 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 8, 1877

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — M.n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Henry Clay Pilchard

14. MOTHER'S MAIDEN NAME: Susan Jane Payne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Cassuis C. Jones, Stockton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Degenerative Heart Disease — Years

DUE TO (c): ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (1) Hypertension (2) Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 19 60 to May 22, 19 60 that I lost saw the deceased alive on May 22, 19 60, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles W Trader M.D.

ADDRESS (Street, city or town, state) — DATE SIGNED: 5/23/60

PHYSICIAN'S NAME (Type): Charles W. Trader, M.D., 302 Market St., Pocomoke City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-24-60

22c. NAME OF CEMETERY OR CREMATORY: Gumby Presbyterian

22d. LOCATION (City, town, or county) (State): Stockton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry L. Watson

ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR — DATE: MAY 26 '60

24b. REGISTRAR'S SIGNATURE: Elmer S. Russell

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6431 **CERTIFICATE OF DEATH** 0639

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Worcester

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City

c. LENGTH OF STAY IN 1b: 40 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural-Pocomoke City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. 1

d STREET ADDRESS: R.F.D. 1

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First CLARA Middle KATHERINE Last MATTLAGE

4. DATE OF DEATH: Month May Day 18 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: George Mattlage

14. MOTHER'S MAIDEN NAME: Clara Spellmeyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: --

17. INFORMANT Address: Mrs Florence Turner, Redbank, New Jersey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	UREMIA	2 WEEKS
DUE TO (b)	CARCINOMATOSIS	6 MONS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	PRIMARY CARCINOMA OF PANCREAS	18 MONS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/2, 19 56 to 5/18, 19 60 that I last saw the deceased alive on 5/17, 19 60, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. D. Hamilton M.D. ADDRESS (Street, city or town, state): 212 MARKET ST. DATE SIGNED: 5/18/60

PHYSICIAN'S NAME (Type): C. STANFORD HAMILTON Pocomoke City, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-20-60

22c. NAME OF CEMETERY OR CREMATION: Presbyterian

22d. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke City, Md.

24a REC'D BY REGISTRAR DATE: MAY 23 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6424 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmC264 6-6-60 et

06392
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c. LENGTH OF STAY IN 1b Four weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Del
b. COUNTY /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46x3
d. STREET ADDRESS 7 Parsley Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Michael Middle Francis Last O'Neill
4. DATE OF DEATH Month 5 Day 28 Year 1960
5. SEX M.
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 23 1918
9. AGE (In years last birthday) 41 Yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Insurance + Investments
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Wilmington Del
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John O'Neill
14. MOTHER'S MAIDEN NAME Rose Flood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO. 142-07-0150
17. INFORMANT Address Mrs Michael O'Neill Wilmington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1
DUE TO (b) A Coronary occlusion (Probable)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH ? Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE N.E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) N.E. Sartorius
DATE SIGNED 5/29/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF June 1st
22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery
22d. LOCATION (City, town, or county) Wilmington (State) Del

23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE JUN 2 '60
24b. REGISTRAR'S SIGNATURE Esther L. Hall

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute ... certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6426 **CERTIFICATE OF DEATH** Reg. Dist. No. 06393

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: R.F.D. # 2 Box 121
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Williams — Middle: Edward — Last: Wise

4. DATE OF DEATH: Month: May — Day: 11 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 23, 1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Work
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Williams Edward Wise, Sr.
14. MOTHER'S MAIDEN NAME: Grace Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-12-0964A
INFORMANT: Mrs. Beulah Hugher
Address: 106 W. Sharpneck ST. Philadelphia, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 mths
DUE TO (b): Hypertensive Cardio-vascular Disease — 4 yrs
DUE TO (c): Glomerulonephritis — 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5927

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign prostatic hypertrophy
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-8, 1960, to 5-9, 1960, that I last saw the deceased alive on 5-9, 1960, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sully Jr. M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 5/13/60

PHYSICIAN'S NAME (Type): Ivory U. Sully Jr. MD Berlin Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5,15/60
22c. NAME OF CEMETERY OR CREMATORY: Wardtown, Cem.
22d. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Edgar Wharton, New Church, Va.

24a. REC'D BY REGISTRAR DATE: MAY 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58